Prepared remarks for the
HIT Standards Committee Implementation Workgroup

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Context: Business Problems Addressed

Microsoft has created two products that address similar problems across two distinct audiences:

HealthVault enables individuals to assemble a comprehensive, lifetime family health record that can be used with an ecosystem of third-party consumer tools -- and shared with others in forms they can use.

HealthVault users want to solve problems such as:

- Avoiding the ubiquitous clipboard
- Ensuring information is fully shared within circles of care
- Being prepared for emergencies
- Knowing they are responsible caretakers

Amalga enables enterprises to assemble a comprehensive, organization-wide "data asset" that can be used for internal analysis and workflow -- and shared with external constituents in forms they can use.

Amalga users want to solve problems such as:

- Measuring and improving quality in their organizations
- Improving clinical workflows and using resources more efficiently
- Maintaining meaningful relationships with their constituents

Each of these problems has its roots in information sharing between diverse entities -- including people and machines – both between and inside organizations. HIT standards are one important tool we have in our kit to try to solve them – but only one. I believe that our policy efforts must focus less on the tactic of creating more and more detailed standards around transactions, and more on defining the minimal set of exchangeable documents required to support the incentives and alignment that will drive positive outcomes.

While I am here to frankly discuss our challenges and opportunities, I should stress that we have been encouraged in recent months by the activity of ONC and others in the industry – the "status quo" seems to be changing and that is very exciting to watch and participate in.

Challenges

Many questions from the committee revolve around standards adoption within large versus small practices. Clearly small practices are looking for simpler paths to technology adoption, and today's

approach of pressing full-scale EMR systems into the hands of unwilling participants has not been effective.

But our experience has been that in truth even large institutions are simply not interested in HIT standards, just as they are not interested in Internet protocols like HTTP. Like all businesses, healthcare enterprises are focused on their economics and on delivering a quality product to their extended constituents: patients, referring community, board of directors, and so on. They will adopt technology only when it helps their day-to-day workflow be more efficient, answers questions they care about but cannot answer today, creates higher customer satisfaction, or opens up new business opportunities.

The large versus small question simply magnifies this problem. Operating on thinner margins, with fewer "levers" to work with, small practices cannot afford to make investments in technology that *may* pay off sometime in the future, if ever. Large enterprises generally have more degrees of freedom in this area, so we see more speculative work, but at the end of the day the same dynamics apply.

Fundamentally, our challenge is to create the environment that will align our desired outcomes – primarily improvements in *system-wide* care quality and efficiency – with the business imperatives that by definition must be the first priority of all care delivery organizations. HITECH is a sledgehammer that will have impact simply by virtue of the dollars involved, but it is our burden to turn that short-term accelerant into sustainable change.

We believe the HIT Standards Committee has an important role to play in this alignment by defining the right focused set of artifacts – documents for exchange – that healthcare enterprises large and small can understand and value as part of accomplishing their business goals.

Success: Continuity of Care / Visit Summaries

Dr. Halamka has said that the CCD/C32 has "revolutionized" exchange at Beth Israel Deaconess. I could not agree more that the snapshot-in-time care document has been a dramatic accelerant to useful exchange. The key is that enterprises large and small "get it" -- a simple, crisp, artifact that captures the most important data elements about a patient intuitively makes sense. Even a paper-based provider can get value from these documents by printing them out for the chart.

The other benefit of this concept is that it has such clear secondary use. Beth Israel shares documents with the Social Security Administration for eligibility purposes. HealthVault accepts and creates them as a way to move information in and out of personal records. New York Presbyterian uses them to communicate visit summaries back to their referring community.

Our experience with these documents leads us to three recommendations for the committee:

1. **Accelerate the concept by endorsing multiple standards.** It is clear from our experience that the challenge to continuity of care exchange has little to do with the specific document format – it lies in the work to assemble and consume structured data in the first place. Many vendors and institutions have made investments in the CCR standard over the past few years, and some express preference for one format over the other. Given demonstrated capabilities around

automated transformation, we see little value for the committee to waste effort on a fight. Instead, the committee should simply endorse both the CCR *and* CCD as acceptable for continuity of care exchange.

2. **Maintain the data inclusivity in the standards.** Both CCD and CCR do an excellent job of balancing between our desire for structured information and the reality of information in the world today. This is core to their success; a format must be comprehensive to be useful.

3. **Stay focused on the artifact.** The re-usability of the document has been another ingredient to its success. By not overly-defining how it should be used or how it can be transmitted, it has been applied to many different situations. This kind of secondary use is "gold" to enterprises and should be reinforced.

Opportunity: Quality Measures

Dr. Blumenthal reiterated at the National Quality Forum conference last week that quality measures are at the core of health reform, and we agree. Many of our customers use the Amalga UIS product as an engine to measure internally- and externally-defined quality measures in near real time. This is another concept -- like continuity of care -- that makes sense both for success of the system and the individual businesses involved.

We believe quality measures are special because, if properly defined and incented, they will indirectly influence exactly the type of HIT adoption we have been unable to force to date – because the act of reporting is unquestionably made simpler and more cost-effective through the use of technology. In addition, because contribution of quality metrics creates specific and immediate value to the nation, it seems reasonable that economic incentives for reporting can be sustained over time.

Of course the standards committee does not define the content of specific measures. But this is an instance where structured data and consistent vocabulary use are true requirements for meaningful outcomes. The standards committee is in the best position to help ensure that:

1. Measures are quantified in a way that maximizes analysis and re-usability of the information, while remaining cognizant of the wide variety of source systems that will be used to derive final values.

2. The standard formats for submission encourage HIT adoption, but can be created on a "sliding scale" of technology as well. For example, a small practice that chooses a spreadsheet application to manually generate reports should still be rewarded for that activity.

In Conclusion

Microsoft of course believes strongly in the value of technology to improve healthcare around the world, and that commonly-accepted standards must play an important role in delivering that value. However, our experiences to date have convinced us that we must find a better way to "pull" standards into our industry rather than trying to "push" them in.

We should concentrate our efforts on a smaller number of scenarios where real business need has created openness to and a visible need for standardization – continuity of care and quality measures being two good examples. We should embrace standards that are working, and not create negative momentum by forcing single standards if more than one can do the job and have support.

Most importantly, we must ensure that, together with the policy and economic actions we are taking throughout the ONC and other agencies, the standards we define align not only with our system-wide goals, but those of the individual businesses delivering care as well – as this is the only way they will truly see sustained adoption.